



CHAPTER 517—COVERED SERVICES, LIMITATIONS, AND EXCLUSIONS FOR PERSONAL CARE SERVICES

CHANGE LOG

Replace	Title	Change Date	Effective Date
Section 517.1	Definitions	4-17-06	6-1-06
Section 517.4	Provider Certification Requirements	4-17-06	6-1-06
Section 517.7.3	Basic Training Requirement	4-17-06	6-1-06
Section 517.12	Services and/or costs not eligible for reimbursement under personal care services	4-17-06	6-1-06
Section 517.13	Family Member Restriction	4-17-06	6-1-06
Section 517.16.1	Initial RN Assessment/Recertification	4-17-06	6-1-06
Section 517.16.3	Documentation	4-17-06	6-1-06
Section 517.16.4	Hands on Direct Care Services	4-17-06	6-1-06
Section 517.18	Prior Authorization for Services Above the Limit	4-17-06	6-1-06
Section 517.18.1	Requires Prior Authorization Packet	4-17-06	6-1-06
Section 517.19	Personal Care and Aged/Disabled Waiver Services	4-17-06	6-1-06
Section 517.12 D	Services and/or costs not eligible for reimbursement under personal care	09/26/05	11/01/05
Section 517.13	Family Member Restriction	09/26/05	11/01/05



Section 517.13.1	Waiver of Family Member Restriction	09/26//05	11/01/05
Section 517.19	Personal Care and Aged/Disabled Waiver Services	09/26/05	11/01/05
Attachment Index		09/26/05	11/01/05
Attachment 2 Note changes in page numbers	Personal Care Medical Eligibility Assessment Form	09/26/05	11/01/05

CHAPTER 517—COVERED SERVICES, LIMITATIONS, AND EXCLUSIONS FOR PERSONAL CARE SERVICES

APRIL 17, 2006

SECTION 517.1

Introduction: Definitions

Old Policy: Job services and TWWIIA (Ticket to Work and Work Incentive Improvement Act) were referenced in personal care employment options

New Policy: No longer reference job service or TWWIIA

Change: Workforce WV Center replaces job service and Social Security (Ticket to Work) replaces TWWIIA

Directions: Replace Section 517.1

SECTION 517.4

Introduction: Provider Certification and Requirements

Old Policy: Does not include introductory sentences: “All providers must agree to abide by applicable federal and state laws, policy manuals, policy changes, and other documents that govern this program. Providers must also agree to subject themselves, their staff, and any and all records pertaining to member service to any audit, desk review, or other service evaluation that ensures compliance with billing regulations and program goals.”

New Policy: Agencies must agree to the above introductory sentences.



Change: Add introductory sentence: “All providers must agree to abide by applicable federal and state laws, policy manuals, policy changes, and other documents that govern this program. Providers must also agree to subject themselves, their staff, and any and all records pertaining to member service to any audit, desk review, or other service evaluation that ensures compliance with billing regulations and program goals.”

Directions: These requirements added.

SECTION 517.7.3

Introduction: Basic Training Requirement

Old Policy: First aid training did not indicate mandatory and confidentiality training was not included.

New Policy: Added (*) to First aid to indicate mandatory training and added training in confidentiality laws and regulations.

Change: First aid is required and confidentiality training is required

Directions: Replace section 517.7.3

SECTION 517.12

Introduction: Added language to services and/or costs not eligible for reimbursement under personal care services

Old Policy: Did not reflect the need for ADW recipient to receive prior authorization.

New Policy: Add (D) “Any personal care services provided to an Aged and Disabled Waiver member that has not received prior authorization. Add (E) “Services that are provided by a member’s spouse or parents of a minor child.

Change: Prior authorization required for the provision of dual ADW and personal care services. Persons not eligible for reimbursement of personal care services limited to member’s spouse or parents of a minor child.

Directions: Replace section 517.12.

SECTION 517.13

Introduction: Limited the family member restriction to two categories.

Old Policy: Restrictions included adult adopted child of an adult adoptive parent, adult sibling including step sibling of a minor child, adult child of an adult member, adult sibling residing with an adult sibling member, parents of an adult child.

New Policy: There are two family member restrictions: (1) Spouse, (2) Parents of a minor child

Change: Restrictions limited to these two categories and no waiver of these family restrictions



Direction: Replace section 517.13 and delete section 517.13.1 waiver of family member restriction

SECTION 517.16.1

Introduction: Initial RN Assessment - Clarified RN's role in dual service provision

Old Policy: Did not have RN involved in opening of dual service provision

New Policy: Added "Initiates opening of dual service provision of ADW and Personal Care, including providers meeting and submission of prior authorization request. (See section 517.19)

Change: RN can initiate opening of dual service provision of ADW and Personal Care

Directions: Replace section 517.16.1

SECTION 517.16.3

Introduction: Documentation- Clarified RN completes standardized documents

Old Policy: Did not indicate completed and signed by the registered nurse

New Policy: Added completed and signed by the registered nurse

Change: Clarified the RN must complete and sign required documentation

Directions: Replace section 517.16.3

SECTION 517.16.4

Introduction: Added prior authorization requirement to T1019

Old Policy: Did not have prior authorization requirement for dual service provision.

New Policy: Added "Prior authorization is required for any provision of dual services to ADW members."

Change: Prior authorization is required for dual service provision.

Directions: Replace section 517.16.4

SECTION 517.18

Introduction: Added prior authorization requirement for the provision of dual service.

Old Policy: Did not indicate prior authorization requirement for the provision of dual services.

New Policy: Prior authorization is required for any provision of dual services to ADW members.

Change: Prior authorization requirement added.

Directions: Replace section 517.18.

SECTION 517.18.1

Introduction: Required prior authorization packet.



Old Policy: Listed several scenarios in which a prior authorization packet will be returned.
New Policy: "Prior authorization packets which have incomplete or inaccurate information will be returned."
Change: All packets with incomplete and inaccurate information will be returned.
Directions: Replace section 517.18.1

SECTION 517.19

Introduction: Personal Care and Aged/Disabled Waiver services.
Old Policy: Did not indicate all documentation required for dual service provision.
New Policy: Added documentation requirements for dual service provision.
Change: Dual service provision requirements provided and replicated ADW dual service provisions.
Directions: Replace section 517.19 and add attachment 17

SEPTEMBER 26, 2005

SECTION 517.12

Introduction: Legal Guardian
Change: Reword letter "D"
Directions: Remove old page and replace with new page.

SECTION 517.13

Introduction: Family Member Restriction.
Change: Remove "step-parent" from "(2)".
Directions: Remove old page and replace with new page.

SECTION 517.13.1

Introduction: Waiver of Family Member Restriction.
Change: Remove "step-parent" from last sentence.
Delete: Added "include legal-guardian(s) along with spouse as not being able to receive reimbursement for providing services" in first paragraph.
Directions: Remove old page and replace with new page.

SECTION 517.19

Introduction: Added section on Personal Care and Aged/Disabled Waiver Services.
Change: Member can receive Personal Care and Aged/Disabled Waiver Services.
Directions: Replace old pages with new pages.



ATTACHMENT INDEX

Introduction: Added index.

Change: Added index for assistance in locating attachments.

Directions: Add new page.

ATTACHMENT 2 PERSONAL CARE MEDICAL ELIGIBILITY FORM

Introduction: Replacing PAS-2005 with Personal Care Medical Eligibility Assessment Form.

Change: Replace PAS-2005 with Personal Care Medical Eligibility Assessment Form.

Directions: Delete PAS-2005.



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CHAPTER 517—COVERED SERVICES, LIMITATIONS, AND EXCLUSIONS FOR PERSONAL CARE SERVICES

INTRODUCTION

The West Virginia (WV) Medicaid Program offers a comprehensive scope of medically necessary medical and mental health services to diagnose and treat eligible members. Covered and authorized services must be rendered by enrolled providers within the scope of their license and in accordance with all state and federal requirements. Any service, procedure, item, or situation not discussed in the manual must be presumed non-covered unless informed otherwise by the Bureau for Medical Services (BMS).

This chapter sets forth the BMS requirements for payment of personal care services provided to eligible West Virginia Medicaid members.

The policies and procedures set forth herein are promulgated as regulations governing the provision of personal care services by personal care providers in the Medicaid Program administered by the West Virginia Department of Health and Human Resources (DHHR) under the provisions of Title XIX of the Social Security Act and Chapter 9 of the Public Welfare Law of West Virginia.

517.1 DEFINITIONS

As used in the Personal Care Program:

Bureau for Medical Services (BMS) - The single state agency responsible for all regulations and policies for all Medicaid reimbursable services.

Employment - Competitive work of at least forty (40) hours per month that occurs in an integrated setting for which a wage at or above the federal minimum wage is received.

Job Seeking - A process of obtaining employment which may continue for no more than twelve (12) months, not necessarily consecutive, without reaching employment (as defined above) and which is indicated by documentation of registration with the individual's local Workforce WV Center service and one of the following:

- Development of an individual job search agreement with the member's service provider agency; or
- Documentation of job readiness from the Division of Rehabilitation Services; or
- Documentation of participation in a Social Security (Ticket to Work) Employment Network.

Medically Necessary - Those activities indicated on the Physician's order (Personal Care Medical Eligibility Assessment - PCMEA) that are determined to be needed services for members.

Nursing Plan of Care - A service-specific and standardized document completed by a registered



nurse that identifies the tasks to be provided to meet the member's assessed needs.

The following are definitions used by the Social Security Administration:

Disability: The definition of disability for medical purposes is the same as those used by Social Security Administration (SSA) in determining eligibility for Social Security Insurance (SSI) or Social Security Disability Insurance (SSDI) based on disability.

As used by the Social Security Administration:

Individual Age 18 or Over

An individual who is age 18 or over is considered to be disabled if he is unable to engage in any substantial gainful activity due to any medically determined physical or mental impairment, which has lasted or can be expected to last for a continuous period of not less than 12 months, or can be expected to result in death.

Individual Under Age 18

The child who is under age 18 is considered to be disabled if he/she has a physical or mental impairment which can be expected to last for at least 12 months and which severely interferes with his process of maturation. Maturation refers to skills and emotional and social development.

An Individual Under Age 18 is Not Considered a Child if He/She:

- Is legally married, or
- Is divorced, or
- He/she is living in a common household with a member of the opposite sex, and they are holding themselves out of the community in which they reside, as husband and wife, or
- He/she is over age 16 and has been emancipated by a court of law.

Blindness: To Meet the Definition of Blindness, an Individual Must Have:

- Central visual acuity of 10/200 or less in the better eye with corrective glasses, or
- A limited visual field of 20 degrees or less in the better eye with the use of eyeglasses.

Consideration of Medical and Social Factors in Determining Disability:

- In determining whether or not an individual is disabled, medical and social factors and the relationship between the two must be considered.
- If the medical information indicates that the individual has an impairment which has lasted or can be expected to last the required length of time, social factors must be



examined to determine the effect of the impairment on the individual.

- When a case is referred to Medical Review Team (MRT) for a disability decision, the worker completes form OFS-RT-1, Social Summary Outline. This form is designed to provide the social information used by the worker to make a presumptive decision and also for the MRT to make the final disability decision.

517.2 PROVIDER PARTICIPATION REQUIREMENTS

Providers of Personal Care Services participating in the Medicaid program must fully meet the standards established by the Secretary of the U. S. Department of Health and Human Services, all applicable State and Federal laws governing the provision of their services, and all regulations contained herein. Providers of personal care services must meet certification standards before they can be enrolled in the Medicaid program.

517.3 COMPREHENSIVE AGREEMENT

In addition to the agreement on the claim form, providers of Personal Care Services shall be required to enter into a comprehensive agreement with BMS stipulating the conditions of participation. The agreement shall continue in effect until it is terminated for cause or mutual agreement of the parties.

517.4 PROVIDER CERTIFICATION REQUIREMENTS

All providers must agree to abide by applicable federal and state laws, policy manuals, policy changes, and other documents that govern this program. Providers must also agree to subject themselves, their staff, and any and all records pertaining to member service to any audit, desk review, or other service evaluation that ensures compliance with billing regulations and program goals.

Only agencies certified by BMS may serve as personal care providers. Certification is dependent upon the agency's ability to satisfy the following performance standards:

- A. Have a valid Certificate of Need (CON) and a valid license, if licensure is applicable to a said agency;
- B. Provide adequate qualified personnel who meet minimum criteria for providers of the personal care program, and who meet applicable licensure and or other credentialing and training criteria. Central Abuse Registry requests are mandatory. All request for Central Abuse Registry (WV Code 15 2C-1) should be directed to the West Virginia State Police, Criminal Identification Bureau, Records Section, 725 Jefferson Road., South Charleston, West Virginia 25309-1698;
- C. Document, at the time of application, the agency's experience in service delivery to the target population to be served, including the number of members being served and geographic area. The document must include the agency's organizational chart with the names of the members on the Board of Directors and a list of staff, which includes their licensure and/or qualifications;



- D. Have approved training for personal care staff and provide an ongoing staff training program which must include OSHA blood borne pathogens training. The agency must also provide a plan of monitoring the assignments of employees providing personal care services to assure that individuals are in compliance with the training requirements and services are provided according to the plan of care and the member's needs are appropriately met. Documentation of approved training program must accompany the application;
- E. Maintain records that indicate payments made for services are supported by documentation; that the services were authorized, and that time spent in the provision of the services to each individual member is documented. Services must be provided in accordance with a registered nurse's plan of care;
- F. Must identify each county in which they will operate. Must have a permanent staffed office if not in each county then in 8 connecting counties and must have available a roster of trained staff available for services in each county of the provider's designated service area;

The West Virginia Specialized Family Care Medley-at-Risk Program administered by the Bureau for Children and Families, Department of Health and Human Resources, is exempt from the provisions of this section (517.4).

517.5 REQUIREMENTS FOR COUNTY OFFICE

All personal care agencies wishing to provide personal care services must meet the following requirements for all offices which cover 8 contiguous counties:

- A. Have a business license issued by the state and a federal tax identification number.
- B. Have a physical facility. A post office box or commercial mailbox will not suffice.
 - 1. The facility must be located within West Virginia.
 - 2. The facility must have at least one entrance that is handicapped accessible to the public and accessible from the street and/or parking lot. Handicapped parking must be available.
 - 3. The physical facility must be open to the public at least 40 hours per week.
 - 4. The facility also must contain secure space for maintaining member records.
- C. Maintain a telephone that is listed under the name of the business locally, or if long distance, a toll free number for assistance. Exclusive use of a beeper number, answering service, pager, facsimile machine, cell phone, or an answering machine does not constitute a primary business telephone but



may be used for after hours or emergency calls.

- D. Appropriate medical documentation on each member must be kept by the Medicaid provider in the office that represents the county where services were provided and made available to the West Virginia Department of Human Resources and/or United States Department of Health and Human Services, Centers for Medicare and Medicaid Services upon request.

To meet the federal requirements of utilization review and quality control, the provider must keep a file on each Medicaid member for whom the Department of Health and Human Resources is billed. This file must contain original documentation supporting the medical necessity for the services provided to the member.

517.6 APPLICATION FOR ENROLLMENT AS A PROVIDER

Any agency with an approved Certificate of Need which meets the certification requirements in 504 is eligible to apply as a provider of personal care services. The agency must apply to Unisys, Inc. and is required to complete an enrollment application. Apply to:

**Unisys - Provider Enrollment
PO Box 625
Charleston, WV 25322**

Any agency which demonstrates compliance by its application and the required accompanying documentation then has an on-site review within 90 days of submission to ensure compliance with program rules and regulations. Upon satisfactory completion of the written application and the on-site review, the applicant is enrolled and certified as a provider of Medicaid personal care services. An agency is not permitted to provide personal care services until this process is complete.

517.7 STAFF QUALIFICATIONS AND TRAINING

Each provider must assure that there is adequate staff in number and qualifications to care for the number of members served. Staff must meet one of the following categories of qualifications:

Administrative: Any staff who performs administrative duties related to personal care services must possess experience, education, and training necessary to discharge the function of his/her position.

Nursing: Any staff that develop, review, monitor, and oversee a nursing plan of care must be currently licensed as a registered nurse in West Virginia.

Direct Care: Any staff that provides hands-on care or other services to a member, according to an approved nursing care plan, must be certified by an approved training program which meets the requirements of this chapter.

517.7.1 Documentation of Staff Qualifications

All documentation of staff qualifications, such as licenses, transcripts, certificates, references, trainings, etc., must be maintained on file by the provider. The provider must have a review process to insure that employees providing personal care services possess the minimum



qualifications outlined in this chapter. Minimum credentials must be verified for new employees, and, thereafter, annually to assure that credentials/licenses remain valid.

517.7.2 Basic and Annual Training Requirements

Each provider agency must have an approved basic training curriculum which prepares non-licensed staff for direct care and service. Such provider training curriculum shall be reviewed and approved by the BMS or its designee to assure that it meets the Basic Training Requirements specified in Section 517.7.3. An agency must comply with applicable provisions of WV Code § 15-2C-1 on Central Abuse Registry.

517.7.3 Basic Training Requirements

New non-licensed direct-care staff who have no training or experience must receive eight (8) hours of basic training before rendering care or unsupervised service to an eligible individual. Within twelve (12) months of the beginning date of employment, the above identified individuals must receive at least twenty-four (24) hours of additional training, for a total of thirty-two (32) hours. The components marked with an asterisk (*) are mandatory training for the initial eight (8) hour basic training. The training must cover:

- A. *Orientation to the agency, community, and services;
- B. How to work with specific populations including the elderly, persons with behavioral disorders, distinct categories of physical or cognitive disabilities;
- C. Body mechanics;
- D. *Personal care skills including, but not limited to (a) bathing; (b) grooming; (c) feeding; (d) toileting; (e) transferring; (f) positioning; (g) ambulation; and (h) vital signs (physician's order is required in addition to this training before non-licensed direct care staff can take vital signs);
- E. Care of the home and personal belongings;
- F. * Safety and accident prevention;
- G. Food, nutrition, meal preparation;
- H. *Occupational Safety and Health Administration Standards related to blood-borne pathogens;
- I. *Cardiopulmonary resuscitation (CPR); and
- J. *First aid training.
- K. Confidentiality laws and regulations (HIPAA)

517.7.4 Substitution of the Basic Training Requirements

The requirements for basic training for non-licensed direct care staff may be waived (components of Section 517.7.3 marked with an asterisk cannot be waived) if they meet one of the following substitution requirements:

- A. Documentation of successful completion of one of the following related training courses: certified nurse aide; home health aide; homemaker aide or other institutional or home-based skill course which has been reviewed and approved as comparable by licensed personnel of the provider agency. Documentation of completion by the training course provider must be maintained in personnel records. Provider agencies must make copies of their training records available upon request by direct care staff.



- B. One year of experience with the type of population being served by the provider. Verification of this requirement must be met by written reference checks and kept in the personnel file.
- C. A competency demonstration review conducted by the provider's licensed staff, a portion of which must be conducted in a supervised home-based setting. The registered nurse must document this review in the personnel file with a description of the demonstration provided, the date, and the location.

517.7.5 Annual In-service Training Requirement

There is no substitution for the eight (8) hour annual in-service requirement. In meeting this requirement, providers must consider the following:

- A. Each individual providing personal care services must be provided with additional training to develop specialized skills or an opportunity to review and enhance skills or review information learned in basic training.
- B. On-the-job training must be provided as needed to instruct the caregiver in specific skills or techniques for individual members.
- C. Assistance in resolving problems in particular case situations may also be used as a training opportunity.
- D. A criteria and methodology for evaluating the overall job performance of each person providing personal care services must be established. The supervising registered nurse for personal care or Family Based Care Specialist in the Medley-at-Risk Program is responsible for performance evaluation of non-licensed direct care staff and must consider evaluation outcomes when developing in-service training for all staff or those individuals with skill deficiencies.

517.8 DISCHARGE POLICIES AND PROCEDURES

The following policies and procedures for discontinuing personal care services must be followed. Discontinuing services for a member still in need of assistance must occur only after appropriate conferences with BMS, the member and member's family. In these cases in which there is still a need for services to be provided, the conference can be a telephone call, fax, or letter. Services for a member are discontinued by a provider agency under the following circumstances:

- A. When the member loses Medicaid eligibility and the member's case is closed by DHHR; services must be discontinued immediately upon notification.
- B. When the provider learns of circumstances that require the closure of a case for reasons including, but not limited to, death, entry into a nursing home, or services are no longer needed. In these circumstances, the provider must notify BMS in writing and request that the member services be discontinued. Services should be discontinued upon notification;
- C. When the member is noncompliant with the agreed upon plan of care, including failure to



follow through with the job search agreement or failure to provide the required documentation for services outside the home. Noncompliance requires persistent actions by the member or family which negate the services provided by the agency. After all alternatives have been explored and exhausted, the provider must notify BMS in writing of the noncompliant acts and request that the member's services be discontinued. The provider must continue services for twenty-one (21) days or until notified by BMS;

- D. When the member or member's family threatens or abuses the personal care aide or other agency staff or creates an unsafe physical environment, i.e., the staff's welfare is in jeopardy and corrective action has failed. The provider must notify BMS of the threatening or abusive acts or other endangering circumstances and may request that the service authorization be discontinued. Continuation of service for the twenty-one (21) days is not required;
- E. When a provider is unable to continue to meet the needs of a member, the provider must notify the state agency in writing and request that the member's service be discontinued or assigned to another provider. The provider must also provide written notice of discharge to the member's family at least twenty-one (21) days prior to the date of discharge. During the twenty-one (21) day period, BMS must assist in making appropriate arrangements with the member for transfer to another agency, institutional placement, or other appropriate care. All such arrangements must continue to assure that the eligible individual retains free and unrestricted choice of willing, qualified providers. Regardless of circumstances, the personal care provider must continue to provide services in accordance with the plan of care for the twenty-one (21) days or until alternate arrangements are made by BMS, whichever occurs first.

517.9 MEMBER APPEAL PROCESS

Refer to Common Chapter 800.

517.10 PERSONAL CARE SERVICES

Personal care services are medically necessary activities or tasks ordered by a physician, which are implemented according to a Nursing Plan of Care developed and supervised by a registered nurse. These services enable people to meet their physical needs and be treated by their physicians as outpatients, rather than on an inpatient or institutional basis. Personal care services are provided in the member's residence, except that services may be provided outside the home when those services are necessary to assist eligible individuals to obtain and retain competitive employment of at least 40 hours per month. Services are designed to assist an individual with a disability as defined by an SSA program (see Section 517.1) perform daily activities on and off the job; these would include activities that the individual would typically perform if he/she did not have a disability. Assistance is in the form of hands-on assistance, as in actually performing a personal care task for a person. Services include those activities related to personal hygiene, dressing, feeding, nutrition, environmental support functions, and health-related tasks. Personal care services can be provided on a continuing basis or on episodic occasions. Services must be:

- Prescribed by a physician on a PCMEA;
- Necessary to the long term maintenance of the member's health and safety;
- Provided pursuant to a plan of care developed by a registered nurse and periodically monitored by a registered nurse; and



- Rendered by an individual who has met the basic training requirements of this manual and is not a member of the member's family.

517.11 LOCATION OF SERVICES

Eligible individuals receive personal care services in their residence, except that services may be provided outside the home when such services are necessary to assist the eligible individual to obtain and retain competitive employment of at least forty (40) hours per month. Locations for obtaining employment may include employment agencies, human resource offices, accommodation preparation appointments, and job interview sites. Personal care services cannot be provided in a hospital, nursing facility, ICF/MR, or any other settings in which nursing services are provided.

517.11.1 Personal Care/Residential Board & Care Homes (Assisted Living)

Agency care providers are agencies that provide personal care to three (3) or more individuals but are not the custodial caregiver agency for those individuals. A custodial caregiver agency is one that provides room, board and other personal care type services to three (3) or more individuals residing in a common residence or living arrangement. In order to avoid conflict of interest and self-referral, custodial caregiver agencies cannot be providers of, or reimbursed for personal care services rendered to their own Medicaid eligible residents.

The following is intended to clarify Medicaid policy regarding the provisions of Medicaid reimbursable personal care services in personal care or residential board and care homes and assisted living facilities:

- A. Medicaid personal care services must not duplicate or replace those services for which a provider is required by law or regulation to provide.
- B. Personal care homes, residential board and care homes, and homes licensed under the behavioral health twenty-four (24) hour residential services, by definition, must provide a certain level of personal care services. A personal care home and a residential board and care home is defined as:

.... any institution, residence, or part thereof that advertised, offered, maintained or operated.... for the express or implied purpose of providing accommodations and personal assistance and supervision, for a period of more than twenty-four (24) hours, to four (4) or more persons who are dependent upon the services of others by reason of physical or mental impairment who may require limited and intermittent nursing care... WV Code §16-5D; §16-15H-2.

- C. Personal assistance is defined as meaning "personal services including, but not limited to, the following: Help in walking, bathing, dressing, feeding, or getting in and out of bed, or supervision required because of the age or mental impairment of the resident." WV Code §16-5D; §16-15H-2.
- D. The fee that individuals pay to residential board and care and personal care homes includes this level of personal assistance. Therefore, Medicaid will not and cannot reimburse for these services.



- E. If a Medicaid certified personal care provider is requested to render services to Medicaid members in personal care or residential board and care homes (assisted living facility), said homes must provide a detailed itemization of all personal care services provided to members and an explanation of what services the home cannot provide and why additional services are required. This itemization of services must accompany the PCMEA; Medicaid will not reimburse for personal care services that are the responsibility of the personal care home or residential board and care homes (assisted living facility) or are duplicative services.

517.12 SERVICES AND/OR COSTS NOT ELIGIBLE FOR REIMBURSEMENT UNDER PERSONAL CARE SERVICES

- A. Room and Board Services: Room and board is defined as the provision of food and shelter including private and common living space; normal and special diet food preparation; linen, bedding, laundering, and laundry supplies; housekeeping duties and lavatory supplies; maintenance and operation of buildings and grounds including fuel, electricity, water supplies and parts, tools to repair and maintain equipment and facilities and the salaries and other costs related to the items listed above. Room and board services, as listed above, apply to those individuals and agency providers that have individuals residing in a common residence or living arrangement and for whom these individuals, or agencies representing those individuals, provide reimbursement to the provider for these services. Medicaid personal care services must not duplicate or replace services for which a provider is required by law or regulation to provide.
- B. Personal care services which have not been certified by a physician on a PCMEA or are not in the approved plan of medically necessary care developed by the registered nurse.
- C. Hours that exceed the sixty (60) hours per member per month limitation that have not received prior authorization.
- D. Any personal care services provided to an aged and disabled waiver member that has not received prior authorization.
- E. Services that are provided by a member's spouse or parents of a minor child.
- F. Supervision and other activities that are considered normal child care that is appropriate for a child of similar age.

517.13 FAMILY MEMBER RESTRICTION

The following family relationships to the member exclude an individual from providing personal care services for purposes of reimbursement by Medicaid:

- (1) Spouse
- (2) Parents of a minor child

517.14 DETERMINATION OF MEDICAL NEED FOR PERSONAL CARE SERVICES



Each member accessing personal care services must have a completed valid PCMEA.

517.14.1 Medicaid Review Team Review for Social Security Disability Determination

For persons who are applying for employment and are not SSI, or SDI eligible, the member or other representatives must request a disability evaluation through BMS by contacting the Office of Behavioral and Alternative Health Care at (304) 558-6002.

517.14.2 Medical Assessment – PCMEA

A PCMEA, (Attachment 2), designated by BMS is used to certify an individual's medical need for personal care service. This medical assessment must be signed and dated by a physician, and becomes the physician's order and certification for personal care services for this individual. The PCMEA must be completed upon application by the patient for personal care services and at least annually thereafter. In addition, a standardized Personal Care Nursing Assessment (Attachment 6) must be completed at least once each six (6) months. However, nursing assessments may be completed more often when a member's condition changes or at ninety (90) day intervals with appropriate documentation of need.

517.14.3 Nursing Review of PCMEA

Upon request for personal care services, a registered nurse must review the PCMEA information to determine that the medical and physical care needs of the applicant meet the medical needs criteria of BMS for reimbursement by Medicaid for personal care services. An annual recertification, utilizing the PCMEA, is required for individuals who require ongoing services. The annual recertification PCMEA must be signed and dated by the physician attesting to the continued need for services.

A registered nurse must sign and date the PCMEA as directed on the form on page four (4), number thirty-four (34). This signature means that the registered nurse verifies by direct observation and assessment that the applicant has met the medical level of care criteria set forth in this manual as necessary for certification/recertification.

517.15 MEDICAL ELIGIBILITY CRITERIA FOR PERSONAL CARE SERVICES

An individual with three (3) or more deficits at the appropriate level in the following functional areas qualifies for personal care services.

The following are the minimum ratings considered as deficits in activities of daily living for the personal care services:

ACTIVITY	OBSERVED LEVEL
Eating	Level II or higher (physical assistance or more)
Bathing	Level II or higher (physical assistance)
Grooming	Level II or higher (physical assistance)



Dressing
Continence

Level II or higher (physical assistance)
Level II/III (occasional incontinence or incontinent)

Orientation

Level III or higher (totally disoriented; comatose)

Transferring

Level III or higher (1 or 2 person assist)

Walking

Level III or higher (1 or 2 person assist)

Wheeling

Level III or higher (situational/total assistance)

An individual may also qualify for personal care level service if he/she has two (2) functional deficits identified as listed above, (items refer to PCMEA) and any one or more of the following conditions indicated on the PCMEA:

- Pressure-sores rated at Stage 3 or 4 (Item #24)
- The individual is incapable of vacating a building (Item #25)
- Professional/Technical Care needs (item #27): The individual has professional or technical care needs which are provided by the individual himself or by a family member for one or more of the following services itemized under #27; (g) suctioning; (h) tracheostomy; (i) ventilator; (k) parenteral fluids; (l) sterile dressings; or (m) irrigations.
- Medication Administration (item #28) indicates that the individual is not capable of administering his/her own medications. Injections are a skilled need and are not considered in this area.

517.15.1 Recertification of Personal Care Services

For individuals who receive personal care on an ongoing basis, recertification by completion of the PCMEA is required at least annually. The effective date of eligibility is the date of the physician's signature. In addition, a personal care nursing assessment must be completed at least every six (6) months.

517.16 COVERED SERVICES

The following are descriptions of personal care services and activities which are reimbursable by Medicaid:

517.16.1 T1001 - Initial RN Assessment/Recertification

Procedure Code: T1001
Service Unit: Event
Limit: 1 per year
Prior Authorization: No

This service includes the following activities, all of which must be completed before the code is billed.

- Nurse's review of physician signed and dated PCMEA: This is done to verify member eligibility for the program.



- Initial or annual member nursing assessment: This is to be completed in the home with documentation to include the Personal Care Services Nursing Assessment Form.
- Development of the nursing plan of care. This is to be initiated in the home with member participation. This includes the 7-day plan of care or 31-day plan of care and provider daily log. If the nurse feels increased service hours are needed at this time, the required information needed for prior authorization is prepared and included with this billing code.
- Initiates opening of dual service provision of ADW and Personal Care, including providers meeting and submission of prior authorization request. (See section 517.19)
- Personal care provider introduction to the member, review of the member's nursing plan of care with the personal care aide, as well as supervision and monitoring of the implementation of the plan of care by the personal care aide is also included with the billing code.

If the member's condition changes at a later date and a need for increased service time are warranted, a prior authorization request should be initiated and that activity would be billed under procedure code T1002, which is currently capped at six (6) units per month.

517.16.2 T1002-Ongoing Assessment and Care Planning

Procedure Code: T1002
Service Unit: 15 minutes
Limit: 6 units per month
Prior Authorization: No

This service includes the following activities which must be performed by a registered nurse:

- A. The required six (6) month assessment and any other assessment that the member's condition indicates with documentation to justify the event. Assessment must include face-to-face, hands-on activity and direct observation of the individual who is being assessed. The nursing assessments must be signed and dated by the registered nurse and member. Assessments must include an employment appraisal at least once a year when both residential and employment settings are indicated in the nursing plan of care yearly.
- B. Development and modification of nursing care plans, either a 7-day or a 31-day care plan at the discretion of the registered nurse writing the plan. (Exception: Prior Authorization requests require both a 7-day and a 31-day care plan.) Nursing care plans must consider any support from family or community support which is available to address care needs. The care plan addresses the member needs identified in the assessment. Plans must be modified as necessary to account for progress, decline or other changes in the member's condition. Since it is a mandatory activity that the nurse reviews and signs the 7-day or 31-day personal care daily log sheets, time spent for this activity is reimbursable by Medicaid. Time spent should be documented in actual minutes.



- C. Monitoring of the implementation of the nursing care plan by non-licensed staff: In this activity, the nurse assesses the quality and appropriateness of care and activity by non-licensed direct care staff and assures that it is provided according to the care plan. This nurse must also assure that environmental support activity does not exceed one-third of the total care activity allotted by the care plan. In unique circumstances, one-on-one training of the direct care provider by the registered nurse is also reimbursable. The purpose of the one-on-one training must be to instruct the attendant in a specific skill or technique, or to assist the attendant in resolving medically related problems in the individual case situation.

Although the goal is to provide assistance to an individual who cannot carry out activities of daily living, when assessing and care planning, the nurse assures that this goal is balanced with the goal of promoting independence and encouraging the highest possible level of function for the individual.

517.16.3 Documentation

The following standardized documents, which must be completed and signed by a registered nurse, are required to substantiate personal care services:

- PCMEA: Initial and annual recertification
- Nursing Plan of Care: 7-day or 31-day
- Nursing Assessment: Initial, six (6) month assessment, and other assessments as necessary with documentation of need.
- Personal Care Daily Log Sheet: Documentation requires the following: Member's name, caregiver's signature and registered nurse's signature, verifying activities completed as written from the plan of care. If there is more than one caregiver, each individual must sign the log and place their initials in the blocks where they provided services.

517.16.4 T1019 - Hands on Direct Care Services

Procedure Code:	T1019
Service Unit:	15 Minutes
Service Limit:	60 hours per month
Prior Authorization:	Yes, any services beyond 60 hours per month and services to obtain and retain employment which exceed the one-third limit for environmental support tasks. Prior authorization is required for any provision of dual services to ADW members.

517.16.5 Definition

This service is defined as hands-on, medically necessary activities and supportive tasks described in the nursing care plan which are implemented by qualified and trained staff as defined under 507.2 and 507.3. Services are provided in the member's residence, except that services may be provided outside the home when those services are necessary to assist eligible individuals to obtain and retain competitive employment of at least forty (40) hours per month (see 517.16.7 below). Staff may provide assistance with such activities as dressing, personal hygiene, feeding, assistance with self-administration of medications, and assist with environmental support tasks such as housecleaning, laundry, bed changing. Environmental



support tasks must not exceed one-third of the allotted activity on the plan of care.

517.16.6 Covered Environmental Support

Environmental support includes light housecleaning, laundry, ironing and mending, bed changing or making, dishwashing, grocery and/or pharmacy shopping, and bill paying.

517.16.7 Additional Covered Service Settings

Personal care services outside the home may be provided during all employment-related activities and during job seeking activities. These activities and tasks enable individuals with physical and/or mental disabilities as defined by SSA program to carry out activities of daily living on and off the job that the individual would typically perform if he/she did not have a disability. These activities include:

- Researching employment opportunities
- Employment applications
- Interviewing
- Pre-employment assessments
- Pre-employment observation periods
- Periods of employment of less than forty (40) hours per month if working toward goal of at least forty (40) hours per month.

517.16.8 Documentation

The documentation required for Procedure Code T1019 includes the Personal Care Daily Log (Attachment 5). This form must be signed by the registered nurse or Family Based Care Specialist in the Medley-at-Risk Program; it must have the original signature of the person providing direct care to the member.

When the nursing plan of care identifies the need for personal care services outside the home, it is the responsibility of the service provider agency to verify and maintain documentation of employment of at least forty (40) hours per month or documentation of job seeking. Appropriate documentation of employment may be in the form of a pay stub or substitute form signed by the employer which indicates the hourly wage, number of hours worked in a specific time period and location of employment. (See Member Wage and Hour Report, Attachment 13.) Documentation of registration with the individual's local Workforce WV Center must also include one of the following:

- Development of an individual job search agreement with the member's service provider agency;
- Documentation of job readiness from the Division of Rehabilitation Services; or
- Documentation of participation in a Social Security (Ticket-to-Work) Employment Network.

The appropriate documentation must be resubmitted to the service provider agency at least once every 3 months and may be submitted via mail, fax, or in person. Copies of this documentation must be maintained by the member's case manager or supervising nurse in a specific employment section of the member's permanent record.



517.17 NON-COVERED SERVICES

Personal care services can only be reimbursed when the nursing plan of care spells out the specific need and incorporates it in planned time. The following services are not covered and/or billable as personal care services:

- Professional skill care such as tube feeding, Foley catheter irrigations, sterile dressings, or other procedures requiring sterile techniques are neither to be performed by non-licensed personal care staff, nor will they be considered reimbursable as personal care services.
- Activities such as training, travel time before or after providing services to an eligible individual, or administrative tasks are not reimbursable as separate activities.
- Environmental Services which are provided as part of the room and board provisions of residential settings are not reimbursable. These residential settings include behavioral health supervised residential homes.
- The registered nurse cannot bill or be reimbursed for telephone calls and preparation of medication boxes.

517.18 PRIOR AUTHORIZATION FOR SERVICES ABOVE THE LIMIT

The following are standardized forms which make up the information and define the process of requesting personal care service beyond sixty (60) hours per month to a maximum of 210 hours per month. Prior authorization is required for any provision of dual services to ADW members.

517.18.1 Required Prior Authorization Packet

- Prior Authorization Cover Sheet (Attachment 1)
- PCMEA (Attachment 2)
- Nursing Plan of Care - 7-day (Attachment 3)
- Nursing Plan of Care - 31-day (Attachment 4)
- Nursing Assessment (Attachment 6)

Prior authorization packets which have incomplete or inaccurate information will be returned.

Personal Care Daily Log Sheets (Attachment 5) are not required as a part of the prior authorization Packet.

517.18.2 Prior Authorization Time Frames

Prior authorization request for members receiving services above the limits may be approved for a maximum of six (6) months. Example: A member receives a prior authorization for July through December for a total of ninety (90) service hours per month. A second prior authorization request for the next six months must be submitted by November 30. All prior authorization packets submitted with complete information and documentation will be approved within thirty (30) days.

Providers may request prior authorization for new members for whom they are initiating services at any time. The same is true for members who may have an acute episode which increases care needs.

517.19 PERSONAL CARE AND AGED/DISABLED WAIVER SERVICES



Approval of the provision of both ADW and PC services to the same person will be considered if the following criteria are met:

- A. Any PC services provided to an active ADW member must be approved by the reviewing agencies (see #H below), including the initial 60 hours. "Dual Service Provision Request" must be completed.
- B. An ADW member must be receiving services at Level of Care D.
- C. All policy set forth in Chapter 517 of the PC Manual, including the family restrictions sections, must be followed. PC policy supercedes ADW policy for this request.
- D. There must be a PC RN Plan of Care and a HM RN Plan of Care. Both plans must be coordinated between the two agencies providing hands-on direct services to ensure that services are not duplicated. PC and HM services cannot be provided during the same hours on the same day. A service planning meeting between the Case Manager (ADW agency or self-directed), HM RN, and PC RN must be held with the member in the member's residence and documented on the "Request for Dual Service Provision."
- E. There must be a valid ADW PAS-2005 (or PAS-2000 if medical assessment completed prior to November 1, 2005) and a valid PC Medical Eligibility Assessment (or PAS-2000 if medical assessment completed prior to November 1, 2005) that documents the need for both services.
- F. The ADW CM will be responsible for assuring that the two programs are being administered according to the policies addressed in each manual. If there is no CMA (member is self-directed), the ADW RN and the PC RN will provide oversight to assure compliance.
- G. Permission to provide PC and ADW services to a member must be requested by the PC RN and signed by the PC RN, CM (or responsible party if self-directed), HM RN, and the member or member's representative. Original signatures are required; i.e., "signature of member on file" is not acceptable.
- H. Senior Centers PC providers should submit requests to:

WV Bureau of Senior Services
State Capitol Complex
1900 Kanawha Blvd. East
Charleston, WV 25305
Fax: 304 558-6647

All other PC providers should submit requests to:
WV Bureau for Medical Services
350 Capitol Street, Room 251
Charleston, WV 25301



Fax: 304 558-1509

I. Documentation submitted must include approved current medical eligibility of both ADW and PC services, ADW and PC RN Plans of Care, RN assessments, and any documentation that substantiates the request. Additionally, a narrative describing how services will be utilized and verification that ADW and PC services will not be duplicated must be submitted, as well as documentation of caregivers for both programs and their relationship to member. Requests will be reviewed by BoSS or BMS RNs. Approvals/denials will be based on the documentation submitted, appropriate program policy manuals, PC standards, and professional judgments. The member or member's representative, PC RN, HM RN, and CM will receive notification of denial or approval from the reviewing agency. If the request is denied or the hours approved are less than requested, the notification will include fair hearing information.

J. BMS will conduct post-payment review of these combined services for duplication or inappropriate services. BoSS and BMS will review compliance during the agency monitoring process.

ATTACHMENT INDEX

- 1 – PRIOR AUTHORIZATION COVER SHEET**
- 2 – PERSONAL CARE MEDICAL ELIGIBILITY ASSESSMENT**
- 3 – NURSING PLAN OF CARE – 7 DAY**
- 4 – NURSING PLAN OF CARE 31-DAYS**
- 5 – PERSONAL CARE DAILY LOG SHEETS**
- 6 – PERSONAL CARE NURSING ASSESSMENT**
- 7 – PERSONAL CARE EMPLOYMENT SUPPORT RECORD SHEET**
- 8 – JOB SEEKING AGREEMENT**
- 9 – EMPLOYMENT STATUS AGREEMENT**
- 10 – EMPLOYER CONTACT SUMMARY SHEET**
- 11 – EMPLOYER FOLLOW-UP SHEET**
- 12 – RELEASE OF INFORMATION**
- 13 – MEMBER WAGE AND HOUR REPORT**
- 14 – NURSING PLAN OF CARE FOR EMPLOYMENT SUPPORT SERVICES**
- 15 – DEFINITIONS OF PERSONAL CARE TERMS**
- 16 – PERSONAL CARE STANDARDS**

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ATTACHMENT 1
PRIOR AUTHORIZATION COVER SHEET
PAGE 1 OF 2

INSTRUCTIONS

It must be filled out completely - no blank spaces.

It must have correct Medicaid number.

It must specify beginning and ending period of request.

It must contain the number of hours per month.

It must have total number of hours for the time period of the request.

It must be sent to correct address depending on the target population.

It must indicate if this is a first time request.

MEDICAID
Personal Care Services
Prior Authorization Cover Sheet

Agency Name: _____
Agency Address: _____
Provider Number: _____
Contact person: _____
Telephone Number: _____
Member Name: _____
Correct Medicaid Number : _____ - _____ - _____
Total Units per month previously approved: _____
Service Period for this request:
_____ to _____
(Beginning) (Ending)
Requesting _____ units per month Submission Date: _____

Total Number of Units for this period: _____
Submit to:
Personal Care Services Prior Authorizations
Bureau of Senior Services
1900 Kanawha Boulevard East
Charleston, WV 25305

OR

Bureau for Medical Services
350 Capital Street, Room 251
Charleston, West Virginia 25301-3707

Please note:

If form is not correctly completed, it will be returned for completion.
For purposes of new format changes, please submit the information
listed below:

- I. A copy of this cover sheet;
- II. A copy of signed PCMEA;
- III. Nursing Plan of Care, 7-day and 31-day Personal Care Plan;
- IV. Current Nursing Assessment; and
- V. Any other information that you feel will help justify your reports.

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ATTACHMENT 2
PERSONAL CARE MEDICAL
ELIGIBILITY ASSESSMENT FORM
PAGE 1 OF 5

INSTRUCTIONS

Must be signed and dated by physician (not physician's assistant or nurse practitioners).

Must be signed and dated by a registered agency nurse.

Each item must be completed. If not applicable, put N/A.

Section III (page 4) must be completed in full.

A physician's order for activities requiring such order must be on the Personal Care Medical Eligibility Assessment Form (page 4 item 33) or attached.

Member or member designee must sign section 19. Name of member on file is acceptable.

PERSONAL CARE MEDICAL ELIGIBILITY ASSESSMENT FORM

Facility/Agency/Person making referral:

NAME: _____ ADDRESS: _____

CONTACT PERSON: _____

PHONE: () _____ FAX: () _____

Check Only One: Personal Care ☐ Initial ☐ Re-Evaluation

I. DEMOGRAPHIC INFORMATION

1. Individual's Full Name		2. Sex <div style="display: flex; justify-content: space-around; font-size: small;">F M</div>		3. Medicaid Number		4. Medicare Number	
5. Address (Including Street/Box, City, State & Zip)						6. Private Insurance	
7. County	8. Social Security Number			9. Birth date (M/D/Y)	10. Age	11. Phone #	
12. Spouse's Name				13. Address (If different from above)			
14. Current living arrangements, including formal and informal support (i.e. family, friends, other services) _____ _____							
15. Name and Address of Provider if applicable _____ _____ _____							
16. Medicaid Waiver Recipient A <input type="checkbox"/> Yes B <input type="checkbox"/> No C <input type="checkbox"/> Aged/Disabled D <input type="checkbox"/> MR/DD							
17. Has the option of Medicaid Waiver been explained to the applicant? A <input type="checkbox"/> Yes B <input type="checkbox"/> No							
18. Check if Applicant has any of the following: <div style="display: flex; flex-wrap: wrap;"> <div style="width: 33%;">a <input type="checkbox"/> Guardian</div> <div style="width: 33%;">d <input type="checkbox"/> Power of Attorney</div> <div style="width: 33%;">g <input type="checkbox"/> Other _____</div> <div style="width: 33%;">b <input type="checkbox"/> Committee</div> <div style="width: 33%;">e <input type="checkbox"/> Durable Power of Attorney</div> <div style="width: 33%;">c <input type="checkbox"/> Medical Power of Attorney</div> <div style="width: 33%;">f <input type="checkbox"/> Living Will</div> </div> <div style="margin-top: 5px;"> Name & Address of the Representative _____ Phone (____) ____-____ _____ </div>							
19. For the purpose of determining my need for appropriate services, I authorize the release of any medical information by the physician to the Department of Health and Human Resources or its representative. X _____ _____ _____ SIGNATURE - Applicant or Person acting for Applicant Relationship Date							

DATE: _____

NAME: _____

II. MEDICAL ASSESSMENT

20. Health Assessment - Include infectious diseases, nutritional needs, prior treatments, degenerative conditions, recent hospitalization(s), and/or surgery(ies) with dates - Date of most recent office visit. (Attach most recent Hospital Discharge Summary and Physical, if available)

21. Normal Vital Signs for the individual

a. Height	b. Weight	c. Blood Pressure	d. Temperature	e. Pulse	f. Respiratory Rate
-----------	-----------	-------------------	----------------	----------	---------------------

22. Check if Abnormal

a <input type="checkbox"/> Eyes	g <input type="checkbox"/> Breasts	m <input type="checkbox"/> Extremities	s <input type="checkbox"/> Musculo-Skeletal
b <input type="checkbox"/> Ears	h <input type="checkbox"/> Lungs	n <input type="checkbox"/> Abdomen	t <input type="checkbox"/> Skin
c <input type="checkbox"/> Nose	i <input type="checkbox"/> Heart	o <input type="checkbox"/> Hernia(s)	u <input type="checkbox"/> Nervous System
d <input type="checkbox"/> Throat	j <input type="checkbox"/> Arteries	p <input type="checkbox"/> Genitalia-male	v <input type="checkbox"/> AllergiesSpecify) _____
e <input type="checkbox"/> Mouth	k <input type="checkbox"/> Veins	q <input type="checkbox"/> Gynecological	_____
f <input type="checkbox"/> Neck	l <input type="checkbox"/> Lymph System	r <input type="checkbox"/> Ano-Rectal	_____

Describe Abnormalities and treatment _____

23. Medical Conditions/Symptoms: (Check all that apply and have been diagnosed by a physician and/or treated with prescription medication.)

a <input type="checkbox"/> Angina-rest _____	e <input type="checkbox"/> Paralysis _____	i <input type="checkbox"/> Diabetes
b <input type="checkbox"/> Angina-exertion _____	f <input type="checkbox"/> Dysphagia _____	j <input type="checkbox"/> Contracture(s)
c <input type="checkbox"/> Dyspnea _____	g <input type="checkbox"/> Aphasia _____	k <input type="checkbox"/> Mental Disorder(s)
d <input type="checkbox"/> Significant Arthritis _____	h <input type="checkbox"/> Pain _____	l <input type="checkbox"/> Other (Specify)

24. Decubitus a ☐ Yes b ☐ No If yes, check the following:

A. Stage _____ B. Size _____ C. Treatment _____

Location

a <input type="checkbox"/> Left Leg	c <input type="checkbox"/> Right Leg	e <input type="checkbox"/> Left Hip	g <input type="checkbox"/> Right Hip
b <input type="checkbox"/> Left Arm	d <input type="checkbox"/> Right Arm	f <input type="checkbox"/> Left Buttock	h <input type="checkbox"/> Right Buttock

Other _____ **Developed at:** a ☐ Home b ☐ Hospital c ☐ Facility

25. Can the individual vacate the building? (Check only one)

a ☐ Independently b ☐ With Supervision c ☐ Mentally Unable d ☐ Physically Unable

DATE: _____

NAME: _____

26. Indicate individual's functional ability in the home for each item with the level number 1, 2, 3 or 4. Nursing care plan must reflect functional abilities of the member in the home.

Item	Level 1	Level 2	Level 3	Level 4
a__ Eating (Not a Meal Prep)	Self/Prompting	Physical Assistance	Total Feed	Tube Fed
b__ Bathing	Self/Prompting	Physical Assistance	Total Care	
c__ Dressing	Self/Prompting	Physical Assistance	Total Care	
d__ Grooming	Self/Prompting	Physical Assistance	Total Care	
e__ Cont./Bladder	Continent	Occas. Incontinence	Incontinent	Catheter
f__ Cont./Bowel	Continent	Occas. Incontinence * less than 3 X p/wk	Incontinent	Colostomy
g__ Orientation	Oriented	Intermittently disoriented	Totally Disoriented	Comatose
h__ Transferring	Independent	Supervised/Assistive Devise	One Person Assistance	Two Person Assistance
i__ Walking	Independent	Supervised/Assistive Devise	One Person Assistance	Two Person Assistance
j__ Wheeling	No Wheelchair	Wheels Independently	Situational Assistance (Doors, etc.)	Total Assistance
k__ Vision	Not Impaired	Impaired /Correctable	Impaired/ Not Correctable	Blind
l__ Hearing	Not Impaired	Impaired/Correctable	Impaired/Not Correctable	Deaf
m__ Communication	Not Impaired	Impaired/Understandable	Understandable with Aids	Inappropriate/ None

27. Professional and technical care needs - check all that apply.

- | | | |
|---|---|--|
| a <input type="checkbox"/> Physical Therapy | f <input type="checkbox"/> Ostomy | k <input type="checkbox"/> Parenteral Fluids |
| b <input type="checkbox"/> Speech Therapy | g <input type="checkbox"/> Suctioning | l <input type="checkbox"/> Sterile Dressings |
| c <input type="checkbox"/> Occupational Therapy | h <input type="checkbox"/> Tracheostomy | m <input type="checkbox"/> Irrigations |
| d <input type="checkbox"/> Inhalation Therapy | i <input type="checkbox"/> Ventilator | n <input type="checkbox"/> Special Skin Care |
| e <input type="checkbox"/> Continuous Oxygen | j <input type="checkbox"/> Dialysis | o <input type="checkbox"/> Other _____ |

28. Individual is capable of administering his/her own medications: ☐ Yes ☐ No
 (An individual is not capable of administering his/her own medications if the prescription medication must be placed in the recipient's hand, mouth, tube, or eye by someone other than the recipient at all times.) Who sets up member's medication: _____

29. Current Medications	Dosage	Frequency

DATE: _____

NAME: _____

30. Current Diagnoses - Check all that apply

- | | |
|---|---|
| a <input type="checkbox"/> None | g <input type="checkbox"/> Schizophrenic Disorder |
| b <input type="checkbox"/> Mental Retardation | h <input type="checkbox"/> Paranoid Disorder |
| c <input type="checkbox"/> Autism | i <input type="checkbox"/> Major Affective Disorder |
| d <input type="checkbox"/> Seizure Disorder (Age at onset _____) | j <input type="checkbox"/> Schizoaffective Disorder |
| e <input type="checkbox"/> Cerebral Palsy | k <input type="checkbox"/> Affective Bipolar Disorder |
| f <input type="checkbox"/> Other Developmental Disability (Specify _____) | l <input type="checkbox"/> Tardive Dyskinesia |
| | m <input type="checkbox"/> Major Depression |
| | n <input type="checkbox"/> Other related conditions (Specify _____) |

31. Clinical and Psychosocial Data - Please check any of the following behaviors which the individual has exhibited in the past two years.

- | | |
|---|---|
| a <input type="checkbox"/> Substance Abuse (Identify) | k <input type="checkbox"/> Seriously Impaired Judgment |
| b <input type="checkbox"/> Combative | l <input type="checkbox"/> Suicidal Thoughts, Ideations/Gestures |
| c <input type="checkbox"/> Withdrawn/Depressed | m <input type="checkbox"/> Cannot Communicate Basic Needs |
| d <input type="checkbox"/> Hallucinations | n <input type="checkbox"/> Talks About His/Her Worthlessness |
| e <input type="checkbox"/> Delusional | o <input type="checkbox"/> Unable to Understand Simple Commands |
| f <input type="checkbox"/> Disoriented | p <input type="checkbox"/> Physically Dangerous to Self and Others, if Unsupervised |
| g <input type="checkbox"/> Bizarre Behavior | q <input type="checkbox"/> Verbally Abusive |
| h <input type="checkbox"/> Bangs Head | r <input type="checkbox"/> Demonstrates Severe Challenging Behaviors |
| i <input type="checkbox"/> Sets Fires | s <input type="checkbox"/> Specialized Training Needs |
| j <input type="checkbox"/> Displays Inappropriate Social Behavior | t <input type="checkbox"/> Sexually Aggressive |

Does the individual have Alzheimer's, multi-infarct, senile dementia, or related condition? Yes__ No__
Other (Specify)

III. PHYSICIAN RECOMMENDATION

32. Prognosis : Check one only: a__ Stable b__ Improving c__ Deteriorating d__ Terminal

Diagnosis: _____

Rehabilitative Potential - Check one only: a__ Good b__ Limited c__ Poor

33. Other Medical Conditions Requiring Physician Orders:

To the best of my knowledge, the patient's medical and related needs are essentially as indicated above (Must be signed by M.D. or D.O.)

Physician's Signature

MD/DO

Date This Assessment Completed:

TYPE OR PRINT Physician's name/address below:

34. RN Signature and Date: _____

DISCLAIMER: Approval of this form does not guarantee eligibility for payment under the State Medicaid Plan.
NOTE: Information gathered from this form may be utilized for statistical/data collection.

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**ATTACHMENT 3
NURSING PLAN OF CARE--7 DAY
PAGE 1 OF 2**

INSTRUCTIONS

RN has choice of 7-day or 31-day plan if no prior authorization (P.A.) is needed.

If prior authorization is needed, both plans need to be completed to submit for P.A.

Both the 7 & 31 Day Plan of Care must include total amount of time plan justifies and marked for total or partial assistance.

RN signature and provider's name must be on both forms.

Activities which are non-billable in personal care should not appear on the plan of care .

Personal care standards and terms should be used when writing a plan of care.

Plan of care should reflect how member is rated on the PCMEA.

NURSING PLAN OF CARE

Agency:	Agency #:	90-Day Review Date:
Member Name:	Medicaid #:	
Member Address:		
R.N. Signature:		Date:

PERSONAL CARE ACTIVITIES	Level of Services to be Provided		Daily Planned Time							Date Service Started
	Part Assist	Total Assist	Mon	Tue	Wed	Thur	Fri	Sat	Sun	
PERSONAL HYGIENE/GROOMING										
A. Grooming										
B. Bathing										
C. Toileting										
D. Dressing										
E. Laundry (incontinent)										
NON-TECH PHYSICAL ASSISTANCE										
A. Repositioning/Transfer										
B. Walking										
C. Medical Equipment										
D. Assistance with Medication										
E. ROM (Per Phys. order)										
F. Vitals (Per Phys. order)										
G. Other (Per Phys. order)										
NUTRITIONAL SUPPORT										
A. Meal Prep										
B. Feeding										
C. Special Dietary Needs										
ENVIRONMENTAL										
A. Housecleaning										
B. Laundry/Ironing										
C. Making/Changing Bed										
D. Dishwashing										
E. Shopping										
F. Payment of Bills										
TOTAL NUMBER OF MINUTES: _____						TOTAL NUMBER OF UNITS: _____				

NOTE: Environmental tasks are incidental to the other tasks identified on the plan of care. The "times planned" on this plan of care are an estimate of the time/services provided to/for the MEMBER. (This excluded time/services normally provided by other members.

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PERSONAL CARE SERVICES
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ATTACHMENT 4
NURSING PLAN OF CARE--31 DAYS
PAGE 1 OF 3

INSTRUCTIONS

RN has choice of 7-day or 31-day plan if no prior authorization (P.A.) is needed.

If prior authorization is needed, both plans need to be completed to submit for P.A.

Both the 7 & 31 Day Plan of Care must include total amount of time plan justifies and marked for total or partial assistance.

RN signature and provider's name must be on both forms.

Activities which are non-billable in personal care should not appear on the plan of care .

Personal care standards and terms should be used when writing a plan of care.

Plan of care should reflect how member is rated on the PCMEA.

Nursing Plan of Care 31 Days

Member's name: _____	Agency & Phone Number: _____
Provider Name: _____	Approved Hours for Member: _____
Medicaid #: _____	Number of Units: _____
30 Day Review Completed by: _____	RN (Please Print) Date: _____
Signature of Completing RN: _____	

P - Partial Assistance														T - Total Assistance																					
PERSONAL CARE TASKS																																			
PERSONAL HYGIENE/GROOMING	P	T	Time	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	Hours/ Minutes
A. Grooming																																			
B. Bathing																																			
C. Toileting																																			
D. Dressing																																			
E. Laundry (incontinent)																																			
TOTAL																																			
NON-TECH PHYSICAL ASSISTANCE	P	T	Time	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	Hours/ Minutes
A. Repositing/Transfer																																			
B. Walking																																			
C. Medical Equipment																																			
D. Assistance with Medication																																			
E. ROM (Per Phys. order)																																			
F. Vitals (Per Phys. order)																																			
G. Other (Per Phys. order)																																			
TOTAL																																			

Nursing Plan of Care 31 Days

NUTRITIONAL SUPPORT	P	T	Time	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	Hours/ Minutes
A. Meal Prep																																			
B. Feeding																																			
C. Special Dietary Needs																																			
TOTAL																																			

ENVIRONMENTAL	P	T	Time	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	Hours/ Minutes
A. Housecleaning																																			
B. Laundry/Ironing																																			
C. Making/Changing Bed																																			
D. Dishwashing																																			
E. Shopping																																			
F. Payment of Bills																																			
TOTAL																																			

				1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	
																																			TOTAL HOURS
																																			TOTAL UNITS

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PERSONAL CARE SERVICES
SEPTEMBER 1, 2005

ATTACHMENT 5
PERSONAL CARE DAILY LOG SHEETS
PAGE 1 OF 3

INSTRUCTIONS

All Information must be complete and reflect activities as they are written on the plan of care, i.e., marked partial or total with times filled in on the left hand column.

A registered nurse's signature is required when log is complete.

The provider who is named on the daily log must also sign the log sheet verifying the activities were provided as outlined.

Any variance from the plan must be explained at the bottom of page 2.

Member's Name:	Agency & Phone Number:
Provider Name:	Approved Hours for Member:
Medicaid #:	Number of Units:
30 Day Review Completed by:	Date:
Signature of Completing RN:	

P - Partial Assistance															T - Total Assistance																							
PERSONAL CARE TASKS																																						
PERSONAL HYGIENE/GROOMING	P	T	Time	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	Hours/ Minutes			
A. Grooming																																						
B. Bathing																																						
C. Toileting																																						
D. Dressing																																						
E. Laundry (incontinent)																																						
TOTAL																																						
NON-TECH PHYSICAL ASSISTANCE	P	T	Time	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	Hours/ Minutes			
A. Repositioning/Transfer																																						
B. Walking																																						
C. Medical Equipment																																						
D. Assistance with Medication																																						
E. ROM (Per Phys. order)																																						
F. Vitals (Per Phys. order)																																						
G. Other (Per Phys. order)																																						
TOTAL																																						
NUTRITIONAL SUPPORT	P	T	Time	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	Hours/ Minutes			
A. Meal Prep																																						
B. Feeding																																						

Personal Care Daily Logs

[illegible]

COMMENTS ABOUT MEMBER FOR RN TO CHECK. ALSO EXPLAIN ANY VARIANCE FROM PLAN OF CARE:

Provider Signature: _____ Date: _____

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PERSONAL CARE SERVICES
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ATTACHMENT 6
PERSONAL CARE NURSING ASSESSMENT
PAGE 1 OF 4

INSTRUCTIONS

Form must be completed at least every 6 months.

Nursing assessment should reflect member's needs as they are on the PCMEA.

If member's condition has changed, a new assessment may be needed.

Nursing assessment should justify time shown on plan of care.

Signature of RN and member are required.

PERSONAL CARE NURSING ASSESSMENT

Attachment 6

Name:	Medicaid Number:
Date of Birth ____ / ____ / ____	Sex: ____ F ____ M
Address:	

TYPE OF RESIDENCE

Lives Alone:	Lives w/ Natural Family:
Shares an Apartment:	Group Home:
Other (please specify):	

MEDICATIONS (Including name, dosage, and time)

1. _____	8. _____
2. _____	9. _____
3. _____	10. _____
4. _____	11. _____
5. _____	12. _____
6. _____	13. _____
7. _____	14. _____

VITAL SIGNS

Height:	Weight:	Blood Pressure:
Temperature:	Pulse:	Respiratory Rate:

PERSONAL CARE NURSING ASSESSMENT

DESCRIBE THE CLIENT'S ABILITY TO PERFORM PERSONAL CARE TASKS

- Grooming/Skin Care - to include care of hair, mouth, nails, skin and teeth.
 Partial Assistance - what does this entail? _____

 Total Assistance - what does this entail? _____

2. Bathing

Tub ____	Shower ____	Bed Bath ____	Bathe Self ____	Sponge ____
----------	-------------	---------------	-----------------	-------------

3. Bladder/Bowel Functions

Continent _____	Incontinent - How often? ____	Bladder _____	Bowel _____
Wears diapers/protective undergarments ____		Needs assistance for toileting ____	
Colostomy ____	Catheter ____	Other ____	

4. Non-Technical Physical Assistance

Ambulates by Self _____	Needs Medical Assistance to ambulate _____		
Uses Wheelchair - please circle one Manual Electric			
Uses Crutches _____	Uses Cane _____	Uses Walker _____	

- Describe personal care activities which are ordered by the patient's physician as it relates to the medical diagnosis: _____

PERSONAL CARE NURSING ASSESSMENT

6. NUTRITION

Self-feed ____	Part. Assist. ____	Total Assist. ____	N/G Tube ____
G-Tube ____	Regular Diet ____	Diabetic Diet ____	Other Diet ____

7. OTHER SOURCES

SSI ____	Veterans ____	Basic Living Skills (Rehab. Services) _____
SSDI ____	Black Lung ____	Day Treatment (Rehab. Services) _____
Means on Wheels _____		Behavior Management (Rehab Services) ____
Other		

8. Employment Appraisal/if applicable: _____

9. Additional comments: _____

Client Signature

RN Signature

Date

Date

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ATTACHMENT 7
PERSONAL CARE EMPLOYMENT SUPPORT RECORD SHEET
PAGE 1 OF 2

Instructions:

The top section must be filled out completely,

Indicate whether the individual is in Job Seeking Status, or Full Employment Status.

Specific documentation is required for each status; place an X next to the item that applies to the individual.

Personal Care Employment Support Record Sheet

(This is intended to be the cover sheet for employment section of the member's file.)

Name: _____ Social Security Number: _____

Medicaid Number: _____ Date: _____

Agency Completing Form: _____

Name/Title of Person Completing Form: _____

Member Personal Care Employment Support Status

Job Seeking Status

_____ Member has provided documentation of registration with their local Workforce WV AND one of the following:

_____ Member has agreed to participate in an Individual Job Search. This Agency will monitor the Job Seeking Agreement. (See Job Seeking Agreement)

_____ Member has provided documentation of eligibility for vocational rehabilitation services from the Division of Rehabilitation Services.

_____ Member has provided documentation of participation in a Social Security (Ticket to Work) Employment Network.

Employment Status

_____ **Partial Employment:** Member has obtained partial employment working less than forty (40) hours per month earning at least minimum wage. The member agrees to maintain a Member Wage and hour Report Form. (See Employment Status Agreement)

_____ Member is progressing toward full employment of forty (40) hours per month with their current employer within three (3) months.

_____ Member is still job seeking to find full employment of at least forty (40) hours per month and agrees to participate in a Job Seeking Agreement.

_____ **Full Employment:** Member has obtained full employment of at least forty (40) hours per month earning at least minimum wage. The member agrees to maintain a Member Wage and Hour Report form. (See Employment Status Agreement.)

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ATTACHMENT 8
JOB SEEKING AGREEMENT
PAGE 1 OF 2

Instructions:

The member must complete the top section of the form.

The member must select and agree to specific job search activities listed on the form.

The member must agree to the Job Seeking Agreement statement and sign the form.

A provider agency signature and date is also required

Job Seeking Agreement

(Agreement to be completed before member begins job seeking.)

Name: _____ SSN: _____

Medicaid Number: _____ Date: _____

Provider Number: _____

Name/Title of Person Monitoring Plan: _____

Plan Dates: From: _____ To: _____

(Check all applicable categories)

_____ **I agree to register and maintain active status with my local Workforce WV AND one of the following:**

_____ **Individual Job Search**

I agree to: 1) Contact Workforce WV when notified of an opening and appear for interviews as schedule. 2) Contact _____ (number) of potential employers per month and record results of an employer contact summary sheet to be reviewed by the agency every three months. 3) Contact at least one half of the employers in person. Or 4) other . (Please describe) _____

_____ **Vocational Rehabilitation Services from the Division of Rehabilitation Services**

I agree to: 1) Make application at the local Division of Rehabilitation Services Office; 2) Provide documentation of eligibility for Vocational Rehabilitation Services; 3) Provide documentation of continued participation in DRS Vocational services to this agency every three months.

_____ **Participation in a Social Security (Ticket- to –Work)Employment Network**

I agree to: 1) Participate in a TWWIA Employment Network Program; 2) Provide documentation of eligibility for a TWWIA Employment Network Program; 3) Provide documentation of continued participation in the **Social Security (Ticket- to –Work)Employment Network** to this agency every three months. (This option is not available at this time.)

Job Seeking Agreement: I understand that personal care services will be provided outside the home ewhen I am employed at least 40 hours per month earning at least minimum wage. Personal care services will be provided for no more than twelve (12) months, not necessarily consecutive, while I am seeking employment or partially employed, working less than forty (40) hours per month. I agree to adhere to the Job Seeking Agreement and to inform my provider agency of any change in my job seeking status. My provider agency will monitor the Job Seeking Agreement and maintain record of the Agreement in my Medicaid file for review by the Bureau for Medical Services.

Member's Signature: _____ Print Name: _____

Agency: _____ Signature: _____ Date: _____

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ATTACHMENT 9
EMPLOYMENT STATUS AGREEMENT
PAGE 1 OF 2

Instruction

The member must complete the top section of the form

Indicate whether the member has obtained full employment or partial employment

Specific documentation and/ or information provided by the member is required

The member must agree with the Employment Status Agreement statement and sign the form

A provider agency signature and date is required

Employment Status Agreement

(Agreement to be completed after member becomes employed.)

Name: _____ SSN: _____

Medicaid Number: _____ Date: _____

Provider Number: _____

Name/Title of Person Monitoring Plan: _____

Plan Dates: From: _____ To: _____

(Check all applicable categories)

 I have obtained full employment.

I am working at least forty (40) hours per month at or above minimum wage. I agree to provide this agency documentation of my employment on a Member Wage and Hour Report Form every three months.

 I have obtained partial employment. My employer has indicated he/she will be able to offer full employment at a later date.

I am working less than forty (40) hours per month due to: _____

I expect to be working at least forty (40) hours per month on or about _____. I agree to provide this agency documentation on my employment on a Member Wage and Hour Report Form every three (3) months.

 I have obtained partial employment. However, my employer has indicated that he/she will not be able to offer full employment.

I am working less than forty (40) hours per month due to : _____

I agree to continue Job Seeking and have entered into a Job Seeking Agreement. I agree to provide this agency documentation of my employment on a Member Wage and Hour Report Form every three (3) months.

I understand that personal care services will be provided outside the home when I am employed at least 40 hours per month earning at least minimum wage. Personal care services will be provided for no more than twelve (12) months, not necessarily consecutive, while I am partially employed, working less than forty (40) hours per month. I agree to notify my provider agency immediately of any change in my enrollment status. My provider agency will monitor the Employment Status Agreement and maintain records of the agreement in my Medicaid file for review by the Bureau for Medical Services.

Member's Signature: _____ Print Name: _____

Agency: _____ Signature: _____ Date: _____

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ATTACHMENT 10
EMPLOYER CONTACT SUMMARY SHEET
PAGE 1 OF 2

Instructions

The member must complete this form.

The member must provide the most accurate and complete information as possible

Employer Contact Summary Sheets
(Form for member to document employer contacts)

Name: _____ SSN: _____

Medicaid Number: _____ Date: _____

Month: _____

Employer: _____ Phone: _____

Address: _____

Contact Person: _____ Title: _____

Position Applied for: _____

Type of Contact (phone, in-person, follow-up, etc.): _____

Source of Lead (newspaper, phone book, Workforce WV, etc.): _____

Results: _____

Employer: _____ Phone: _____

Address: _____

Contact Person: _____ Title: _____

Position Applied for: _____

Type of Contact (phone, in-person, follow-up, etc.): _____

Source of Lead (newspaper, phone book, Workforce WV, etc.): _____

Results: _____

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ATTACHMENT 11
EMPLOYER FOLLOW-UP SHEET
PAGE 1 OF 2

Instructions

The provider agency must complete this form

Record information on this form to verify an individual's employer contact

The provider agency should obtain appropriate release of information before contacting an member's employer contact

Employer Follow-up Sheet
(Form for provider agency to document member's employer contact)

Name: _____ SSN: _____

Medicaid Number: _____ Date: _____

Person/Title Completing Follow-up Form: _____

Agency: _____

<p>Employer Name & Address:</p> <p>_____</p> <p>_____</p> <p>Person Contacted/Title: _____</p> <p>Results of Contact with Employer: _____</p> <p>_____</p>
<p>Employer Name & Address:</p> <p>_____</p> <p>_____</p> <p>Person Contacted/Title: _____</p> <p>Results of Contact with Employer: _____</p> <p>_____</p>
<p>Employer Name & Address:</p> <p>_____</p> <p>_____</p> <p>Person Contacted/Title: _____</p> <p>Results of Contact with Employer: _____</p> <p>_____</p>

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ATTACHMENT 12
RELEASE OF INFORMATION
PAGE 1 OF 2

INSTRUCTIONS

THE MEMBER MUST FILL OUT THIS FORM COMPLETELY WITH SIGNATURE AND DATE.

(Agency Letterhead)

RELEASE OF INFORMATION

Name: _____

Social Security Number: _____ Date of Birth: _____

I authorize you to furnish any information regarding my application or employment status with your company to _____

(Provider Agency, Address Phone Number)

Signature: _____

Print Name: _____ Date: _____

Address: _____

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PERSONAL CARE SERVICES
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ATTACHMENT 13
MEMBER WAGE AND HOUR REPORT
PAGE 1 OF 2

INSTRUCTIONS

**THIS FORM CAN BE COMPLETED BY THE WORKING MEMBER, THE EMPLOYER, OR
THE PROVIDER AGENCY**

THE EMPLOYER'S SIGNATURE IS REQUIRED

MEMBER WAGE AND HOUR REPORT

PERSONAL CARE - Job Seeking/Employment Status Form 1XX Revised 03-03

EMPLOYER	BEGINNING DATE	ENDING DATE	HOURS WORKED	GROSS PAY

Employer's signature _____ Date _____

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PERSONAL CARE SERVICES
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ATTACHMENT 14
NURSING PLAN OF CARE FOR EMPLOYMENT SUPPORT SERVICES
PAGE 1 OF 2

INSTRUCTIONS

THIS FORM MUST BE COMPLETED BY THE RN RESPONSIBLE FOR NURSING ASSESSMENTS

INDICATE THE PERSONAL CARE ACTIVITIES THAT ARE NEEDED AT THE WORKSITE, THE LEVEL OF SERVICES, AND THE SCHEDULE FOR THE SERVICES ON THE CHART

COMPLETE THE REMAINING ITEMS ON THE FORM, INCLUDING COMMENTS, IF NECESSARY

THE RN MUST SIGN THE FORM

**NURSING PLAN OF CARE
EMPLOYMENT SUPPORT SERVICES**

PROVIDER: _____ **Provider # :** _____ **90 Day Review Date:** _____

Member Name: _____ **Medicaid # :** _____

Member Address: _____ **RN Signature:** _____

Personal Care Activities	Level of Services to be provided		Daily Planned Time							Date Services Started	Comments
	Partial Assis	Total Assist	Sun	Mon	Tue	Wed	Thu	Fri	Sat		
Grooming											
Toileting											
Reposition/Transfer											
Walking											
Medical Equipment											
Assist w/meds											
Meal Prep											
Feeding											
Special Dietary Needs											

Total Number of Minutes: _____ Total Number of Units: _____

Mode of Transportation: _____

Name of Person Providing the Services: _____

Member's Employer (if applicable) : _____

COMMENTS:

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ATTACHMENT 15
DEFINITIONS OF PERSONAL CARE TERMS
USED WITH STANDARDS IN DEVELOPMENT OF PLAN OF CARE

DEFINITIONS OF PERSONAL CARE TERMS

(to be considered when a Plan of Care is written)

1. Partial Assistance: Hand-on assistance with an activity; however, the members can participate to a limited degree.
2. Total Assistance: Hands-on activity where member is incapable of participating in the activity and the provider must perform all services.
3. Medically Necessary: Those services indicated on the Physician's order that must be ordered by the Physician as needed services for member.

Personal Hygiene/Grooming

1. Toileting: Diapering does not apply to babies up to three (3) years old unless extenuating medical circumstances apply.

Partial Assistance: Hands on assistance such as assisting on and off the toilet, bedpan, commode. Not necessary for provider to clean person.

Total Assistance: Hands on. Physically placing member on toilet, cleaning after completing elimination and return to chair, bed, etc....
2. Dressing:

Partial Assistance: Assisting member by laying out clothes, helping member put clothes on. Can dress themselves but needs some hands on assistance.

Total Assistance: Provider must completely dress member from laying out clothes to physically putting on all wearing apparel.
3. Medically Incontinent Laundry:

Laundry requested beyond normal weekly routine. The only approved laundry for incontinence will be that which is considered "Medically" necessary only. Incontinent Laundry is not appropriate for ages birth to three (3) unless extenuating medical circumstances apply.
4. Skin Care:

Routine skin care such as applying body lotion after bathing, or application of suntan lotion is not considered medically necessary. Skin care that would be acceptable would be special lotions for psoriasis, skin breakdown or other medically recognized skin conditions.

Non-Technical Physical Assistance:

1. Non-skilled Medical Care such as B/P monitoring for a Diagnosis of Hypertension must be "Medically" necessary as prescribed by the physician's order which clearly instructs all specifics necessary to carry out the function.
2. Range of Motion, Nebulizer treatments, or changing of a simple dressing are examples of activities needing a physician's order which specifically describes the activities needed and the number of times per day and length of time per session needed.

3. Medical Equipment: Use and care of any medical equipment necessary to maintain member's needs in the home. List all equipment and how it pertains to the plan of care.
4. Walking: In order to have billable time for this activity on the Plan of Care, member needs to be rated a Level III on the PCMEA, indicating "hands-on-assistance."

Nutritional Support:

1. Feeding: Is considered normal activity for babies birth to two (2) years old except for extenuating medical circumstances.

Partial Assistance: In regards to feeding; for example, means cutting up meat on plate or setting up plate.
Total Assistance: In regards to feeding; for example, placing food on fork/spoon and placing in members mouth, prompting them to chew and swallow.

In regards to drinking; for example, holding up of liquid, placing it to their mouth and prompting them to swallow.
2. Meal Preparation: Making preparations of food to be consumed by member.

Partial Assistance: An example of this is taking a frozen dinner out of the paper carton or assisting the member to carrying food to table.

Total Assistance: An example of this is the provider may be cutting up, cooking, watching and otherwise preparing an entire meal for the member who is physically/mentally incapable of assisting in the preparations.

In group home settings of three (3) or more members in one household, meal preparation must be pro-rated across all individuals who will eat the meal. For example, if there are six (6) members and it takes an hour to prepare a meal, each member maximum of ten (10) minutes per meal. If member participates in day program outside his/her residence, the maximum would be ten (10) minutes two (2) times to equal to 20 minutes.

Other:

1. Seizure activity - Is limited to protecting a member during or immediately after the seizure. **Monitoring for seizures is not billable.**
2. Room and Board Payments - Monies paid to an individual/agency on a monthly basis, from the members accounts (SSI) or the Department of Health and Human Resources (DHHR), Bureau of Social Services. Payments of Room and Board from either resource will exclude certain services as listed in the Personal Care Standards.
3. Incident - When an activity states 'per incident' it means each time the activity occurs. An example is taking medications. A member may be on medications that must be taken five (5) times a day. Each of those five (5) times would be a separate incident.

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ATTACHMENT 16
PERSONAL CARE STANDARDS
PAGE 1 OF 4

PERSONAL CARE ACTIVITIES	PARTIAL ASSISTANCE LEVEL II	TOTAL ASSISTANCE LEVEL III	TOTAL MAX. MINUTES/DAY Additional documentation required when using these times.
--------------------------	-----------------------------------	-------------------------------	--

PERSONAL HYGIENE / GROOMING

Grooming/Routine Skin Care: Includes care of hair, skin, nails, teeth & mouth		up to 10 minutes per day	up to 15 minutes per day	up to 60 minutes per day
Bathing; in bed, the tub or in the shower		up to 15 minutes per day	up to 30 minutes per day	up to 30 minutes per day
Toileting:	Diapering : Child	N/A	5 minutes per incident	up to 30 minutes per day
	Diapering: Adult	N/A	up to 30 minutes per incident	up to 180 minutes per day
	Assistance on and off the commode, bedpan, toilet	up to 5 minutes per incident	up to 15 minutes per incident	up to 75 minutes per day 24 hrs.
Dressing		up to 15 minutes per incident	up to 30 minutes per day	up to 30 minutes per day
Medically Incontinent Laundry	Urine, feces (drooling)	up to 30 minutes 2 X a week – occasional incontinence	up to 30 minutes per day	up to 30 minutes per day
NON-TECH. PHYSICAL ASSISTANCE				
Repositioning / Transfer; i.e. in & out of bed, on or off seats		5 minutes per incident	5 minutes per incident	up to 1 hour in 24 hours
Walking: with or without assistance of medical equip, in home		N/A	up to 30 minutes per day	up to 30 minutes per day
Medical Equip: list use and care of equipment in the home		15 minutes per day	up to 30 minutes per day	up to 30 minutes per day
Wheelchair: assistance pushing, loading & unloading in vehicle		up to 30 minutes per day	up to 30 minutes per day	up to 30 minutes per day
Range of Motion: assist with active & or passive ROM (Per P.O.)		Up to 60 minutes per day	up to 60 minutes per day	up to 60 minutes per day
Assist with Medication: includes prompting at right time, provide liquid & assistance in self-medication. Documentation of who prepares medication.		5 minutes per incident	5 minutes per incident	will depend: based on the number of times medications are ordered in 24 hours
Vital Signs: (As per Physician's Orders)		5 minutes per incident	5 minutes per incident	up to 30 minutes in 24 hr. period
Other: As per Physician's orders				

PERSONAL CARE ACTIVITIES	PARTIAL ASSISTANCE LEVEL II	TOTAL ASSISTANCE LEVEL III	TOTAL MAX. MINUTE/ DAY Additional documentation required when using these times
--------------------------	---------------------------------------	-------------------------------	---

**** The Following Standards apply only to those consumers that DO NOT pay for room and board to their provider of service:**

NUTRITIONAL SUPPORT:

Meal Preparation: *Please note: only for those consumers who DO NOT pay for room & board (If a member lives in a group home situation, please refer to definitions.)	up to 15 minutes per meal	up to 15 minutes per meal	up to 45 minutes per day
Feeding	up to 15 minutes per meal	up to 30 minutes per meal	up to 90 minutes per day
Special Dietary Need: Pureed food, extra hydration with documentation	up to 15 minutes	up to 30 minutes	up to 30 minutes per meal

Environments: can count only 1/3 of time spent. ** can only count units for those consumers who DO NOT pay for board and room.

ENVIRONMENTAL:

House cleaning: i.e. dusting & vacuuming rooms consumer uses	up to 10 minutes per day	up to 10 minutes per day	up to 60 minutes per week
Laundry / Ironing & Mending:	up to 60 minutes per week	up to 60 minutes per week	up to 60 minutes per week
Making and Changing Beds:	5 minutes per day	5 minutes per day	15 minutes per day
Dishwashing: This time based on only washing consumer's dishes	up to 10 minutes per meal	up to 10 minutes per meal	up to 10 minutes per meal
Shopping: Time based on shopping for the consumer	up to 60 minutes per week	up to 60 minutes per week	up to 60 minutes per week

Payment of Bills: Only those bills of the consumer	up to 30 minutes per month	up to 30 minutes per month	up to 30 minutes per month
Seizure Activity; this time includes protecting consumer during & right after the seizure only with supporting documentation	5 to 30 minutes per incident	5 to 30 minutes per incident	5 to 30 minutes per incident

CHAPTER 517
PERSONAL CARE SERVICES
SEPTEMBER 1, 2005

ATTACHMENT 17
DUAL SERVICES PROVISION REQUEST
PAGE 1 OF 4

Instructions:

Please see section 519.19 for complete information about request to provide the same member with ADW and Personal Care Services.

WEST VIRGINIA MEDICAID
AGED & DISABLED WAIVER AND PERSONAL CARE
DUAL SERVICE PROVISION REQUEST

MEMBER INFORMATION

Submission Date: _____

Name: _____ Medicaid #: _____

Current ADW LOC: _____

REQUEST INFORMATION

Period for this Request (NO LONGER THAN 6 MONTHS): _____ to _____

Requested PC units per month: _____ Total Number of PC units for the Requested Period: _____

AGENCY INFORMATION

Current ADW HMA: _____ Current CMA: _____

PC Agency: _____ Provider #: _____

PC Address: _____

PC Phone #: _____ FAX #: _____

DATE OF HM RN, CM, PC RN, AND MEMBER MEETING: _____

SIGNATURE OF ADW HM RN

SIGNATURE OF CM

SIGNATURE OF REQUESTING PC RN

SIGNATURE OF MEMBER OR REPRESENTATIVE

REQUIRED DATA TO BE SUBMITTED WITH THIS FORM:

1. A completed copy of this cover sheet with original signatures.
2. A narrative describing how services will be utilized and verification that the ADW & PC services will not be duplicated.
3. Documentation of caregivers for both programs and their relationship to member.
4. Current ADW PAS 2005, or PAS 2000 if prior to 11/2005.
5. Current PC Medical Eligibility Assessment, or PAS 2000 if prior to 11/2005.
6. Current ADW and PC RN Assessments.
7. Current ADW RN POC.
8. Proposed PC POC.
9. Any additional documentation that substantiates the request.

SENIOR CENTER PROVIDERS SEND REQUESTS TO:

WV Bureau of Senior Services

State Capitol Complex

1900 Kanawha Blvd. E.

Charleston, WV 25305

FAX: (304) 558-6647

ALL OTHER PROVIDERS SEND REQUESTS TO:

WV Bureau for Medical Services

350 Capitol Street, Room 251

Charleston, WV 25301

FAX: (304) 558-1509